VOL. 16, NO. 4 APRIL-JUNE, 1967

Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

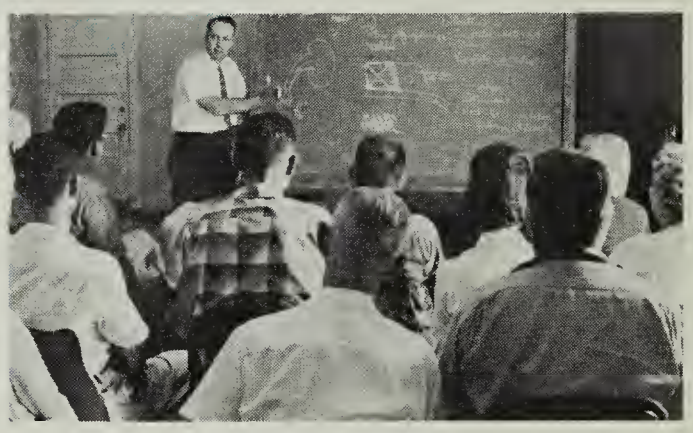
PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.



A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $120 is payable at the time of admission. Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

R. J. BLACKLEY, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

APRIL-JUNE, 1967

VOLUME 16 NUMBER 4

RALEIGH, N. C.

An educational Journal on Alcohol and Alcoholism. Published quarterly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 2100 Hillsboro St., Raleigh, North Carolina, 27607.

LILLIAN PIKE
Editor

ELEANOR BROOKS
Circulation Manager

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina 27603.

SECOND-CLASS POSTAGE PAID AT RALEIGH, N. C. 27602

Insights about alcoholism gained from clinical and social psychiatry can be helpful to anyone working with alcoholics regardless of their professional discipline.

The Psychodynamic Aspects of Alcoholism

BY JOSEPH ADLESTEIN, M.D.

Published by permission of the author, Dr. Joseph Adlestein of Philadelphia, Pennsylvania, the director of special projects, Friends Hospital—Jefferson Medical College Program. Among other special projects, he is responsible for developing existing services at Friends Hospital for patients suffering from disorders of alcoholism and drug dependence. He has served on the faculty of the former Yale School of Alcohol Studies, has headed state mental hospital and community health programs in Pennsylvania and is currently a consultant to the National Institute of Mental Health.

ALTHOUGH alcoholism is a complex medical-social-psychological disorder and as such more than just a psychiatric problem, nevertheless the insights gained from clinical and social psychiatry in this field can be helpful to anyone working with alcoholics, regardless of their professional discipline.

There is a vast array of psychodynamic theories as to the nature of alcoholism. In addition to the psychoanalytical theories, there is also an array of non-psychoanalytical theories having to do with disturbed child-parent relationships, emotional insecurity, introversion-extroversion problems, learning theories, conditioned reflex theories, etc. Descriptive reviews or analyses of alcoholics seen in various clinical settings report—according to the series this is being reported upon—that alcoholics are homosexuals; alcoholics are psychopaths; alcoholics are passive, dependent, immature personalities; alcoholics are latent schizophrenics; alcoholics are obsessive - compulsive personalities; alcoholics are suffering from depressive reactions, etc. Pick any form of neurotic or personality disorder, and it is not hard to find a report stressing this disorder as

the underlying basis of alcoholism in that reported series of alcoholism.

Even the most superficial review quickly establishes that in this field there is a welter of theories—many contradictory. In general, the whole picture seems to be of such utter confusion that one is tempted to say, "A plague on all your houses." But yet, if one looks more closely, the picture is not quite so bad, especially if one begins to examine some of the causes of the confusion. The clinicians and researchers who have formulated many of these theories certainly cannot all be stupid—or blind—or biased—or incompetent. Quite the contrary, many are among the most competent and authoritative people in their respective fields. But then, why the contradictions and confusions?

Knowledge concerning alcoholism is very new as a science, although general knowledge and concern for the problems of alcohol is quite evident in the earliest writing of man. Each of our theorists, by the very nature of things, has been able to see only an infinitesimal segment of the total number of alcoholics and thus is able to abstract and generalize in regard to only this small segment. Again, each sees a very selective sample of patients according to the type of practice he has, the nature of the facility he practices in, or the nature of the setting from which he draws his research material. In addition, it needs to be pointed out that medicine, as every other human endeavor, must be seen as being within a matrix of economic, political, social, and cultural elements. Its particular philosophy and practices are determined to a considerable extent by the current cultural conditions of its locality and time. As this body of knowledge about alcoholism continues to grow, one may be sure that there will be a closer rapprochement between the various divergent theories existing at present. But even today, with all the confusion and divergent views that do exist, if one looks at the commonalities, rather than the contradictions, there is much that can be extracted that can be helpful in our practical day-to-day operations.

What are these areas of commonality? In general, alcohol patients appear to be:

1. Suffering from feelings of estrangement and isolation;
2. depressed and suffering from feelings of hopelessness, sadness, and futility;
3. markedly dependent upon external agents for security and care;
4. hostile, with their patterns of adaptation being marked by a sometimes overwhelming amount of chronic rage suffusing the entire personality;
5. Sexually immature in the sense of having problems with sexual identification.

Other than the above generalizations, one really cannot arrive at a specific personality profile of an alcoholic. Rather, we are concerned with people having a variety of problems, all of which seem to involve a certain amount of tension and anxiety leading to the use of alcohol as the means of coping with the pain of this tension and anxiety. Yet this "pain" is also experienced by a multitude of other people who use alcohol—for taste, as a relaxant, as a social lubricant, etc.—but not as a coping mechanism. Apparently many alcoholics for many different reasons have failed to develop other mechanisms than the use of alcohol for this purpose. Thus it appears that they learn through experience that alcohol, as nothing else would, re-

(Continued on page 22)

Value to Junior High Teacher

Would you please add my name to your mailing list? I am a former social worker and presently teaching at the junior high level. *Inventory* would be of immense value to me. Any former issues still available would also be greatly appreciated.

Mrs. Ben H. Grant, Jr.
Asheville, N. C.

Used by Probation Officer

In continuing to seek new approaches in the treatment of the alcoholic, I have found the ideas and information in your booklets very helpful. Also your January-March, 1967, issue of *Inventory* and the article, "Hints on Helping the Alcoholic Probationer or Parolee," was particularly interesting to me as an officer of the court.

Braxton L. Lane
State Probation Officer
Smithfield, N. C.

Nurse Education

The Catawba Valley Technical Institute has added to its curricula a Practical Nurse Education Program.

Please place our name on your mailing list.

Louise Yount, R.N.
Supervisor-Teacher
Hickory, N. C.

Alcoholism Training Facility

Recently your *Manual on Alcoholism for Social Workers* came to my attention. You are to be congratulated for the interest you have evidenced in this area.

I am very anxious to procure two copies of this publication for our department. As you may know, we are the largest treatment and training facility for alcoholism in Iowa. I am of the definite opinion that this resource should very definitely be a part of our required readings for those doing a residency in our training program.

Wayne K. Wright, Director
Alcoholism Services
Mental Health Institute
Independence, Iowa

Treats Alcoholics

Please include my name on your mailing list for *Inventory*. I am a member of the Psychiatry Department at the College of Osteopathic Medicine and Surgery where we are treating a great many alcoholics. We also have a special program set up with the Salvation Army here in Des Moines, where we do both group and individual testing and therapy.

Harry Liventals
Des Moines, Iowa

Industrial Alcoholism Program

Please send *Inventory* to Dr. H. D. Belk, Medical Director, Western Electric Company, Inc. and Mr. S. W. Plotz, Section Chief, Safety and Accident Benefit Service, Western Electric Company, Inc. These individuals are responsible for the Alcoholic Rehabilitation Program at Western Electric Company, North Carolina works.

T. A. Gilyard
Department Chief
Benefit and Safety Service
Western Electric Company, Inc.
Winston-Salem, N. C.

VOL. 16, NO. 4 INVENTORY APRIL-JUNE, 1967

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The mechanisms and symptoms of addiction occur without the use of drugs and thus without the complications of their chemical effects.

Gambling—

AN ADDICTION

BY
MILO TYNDEL, M.D., Ph.D., F.A.P.A.

Reprinted by permission from *Addictions* (Vol. 10, No. 2, 1963), published by the Alcoholism and Drug Addiction Research Foundation of Ontario. Dr. Tyndel is a research psychiatrist at the Foundation.

EVER so often when we are dealing with patients who have drinking problems, we find that at one time or another these patients were engaged in gambling. We often get the idea that these persons, by continuing drinking in spite of their insight and experience, are jeopardizing their health, life, social and economic position, and their relationship with their family and the community. Frequently, there is a striking similarity between gambling and what is at stake in the abuse of alcohol to the point where we are inclined to view alcoholism as a sort of gambling.

Our aim here is to review the psychological features common to gamblers, with an attempt to present gambling not as a vice or a crime, although it may have features of each of these, but as the expression of underlying serious psychopathology.

The term, gambling, is defined as playing games of chance for money, especially for high stakes; taking great risks to secure great results in war, finance and so on; and finally, risking or wagering something of value upon a chance. In all of these definitions, we find two words which seem to be most important in this context: chance and risk. Chance is defined as an unforeseen occurrence, an accident, an opportunity, a possibility. It is derived from the Latin word "cado" meaning "I fall." Synonymous words are fortune, hazard, fate and casualty. The word, risk, defined as danger, peril, exposure to hurt or loss, or the hazard of loss, is derived from the Latin "resecare", meaning "to cut off." Synonymous words are venture and jeopardy.

The meaning of all these words leaves no doubt about the fact that the individual has no power over the outcome of his act, the outcome being in the hands of some superior unknown power. The individual's only alternative, if he is to take his loss in stride, is to abstain from taking a chance—and this is precisely what he is unable to do if he is a gambler. As a matter of fact, everybody is gambling in one way or another by betting, playing games of chance, or taking chances in a variety of ways. Still, not everybody is a gambler. In order to label a person

as a gambler, we must find certain patterns of behavior and psychopathologic features which characterize him as a gambler, in contrast with the average person who would, on occasion, have similar features without, however, being overpowered by them to any considerable extent.

While the world literature of fiction has a great number of classical descriptions of the gambler and his gambling, of which Dostojewsky's "The Gambler" is the most important, the psychiatric literature is amazingly poor in this respect. Textbooks and handbooks of psychiatry either ignore gambling completely or just mention it in passing, in some instances as just another type of psychopathic personality. I think this is due to the fact that very few doctors, including psychiatrists, are dealing professionally with gamblers. Although, due to its serious social consequences, gambling must be considered a social illness, it cannot be compared with drinking in its scope and importance. It may cause both personal and family tragedy; it may affect business companies through embezzling; but it never affects large sectors of society as drinking does.

Only some psychoanalysts, among them Freud, Menninger, Kris, Simmel, Bergler, Fenichel and Galdston, have paid more attention to the personality of the gambler. This is perhaps due to the fact that analysts are the only therapists who have personal experience in treating gamblers and dealing with their problems, although one might suspect that the gambler would very seldom, if ever, seek help by himself because he would never recognize and admit that his gambling is the expression of a deep emotional disturbance, that is, the symptom of an illness.

According to Bergler, there are six descriptive characteristics of a gambler:

1. The gambler habitually takes chances.
2. The game precludes all other interests.
3. The gambler is full of optimism and never learns from defeat.
4. The gambler never stops when winning.
5. Despite initial caution, the gambler eventually risks too much.
6. "Pleasure — painful tension" (thrill) is experienced during the game.

Right away, we find some striking similarities with the alcoholic, although it is much more difficult to describe the "typical" alcoholic. However, allowances must be made for a variety of types of alcoholism, and only the hard core of alcoholics is considered. The alcoholic's interest in drinking also precludes all other interests to a high degree. He, too, is full of optimism concerning his ability to stop drinking and return to a normal life. He also starts with occasional social drinking with apparently no risks involved and ends up being an alcoholic. He, too, has pleasurable feelings while drinking although these feelings may be mixed with unpleasant, remorseful ones.

The gambler's conscious motivation for gambling boils down to two stock answers. First, he gambles because he wants to win money—by which he means big money and quickly—and this appears impossible through working. Secondly, he gambles because life is boring and gambling gives him thrills and excitement. The gambler usually has a number of irrational arguments in favor of his gambling which, to him, are convincing:

1. He is certain that he will win. This certainty is that of a fanatic in

his belief of ultimate success.

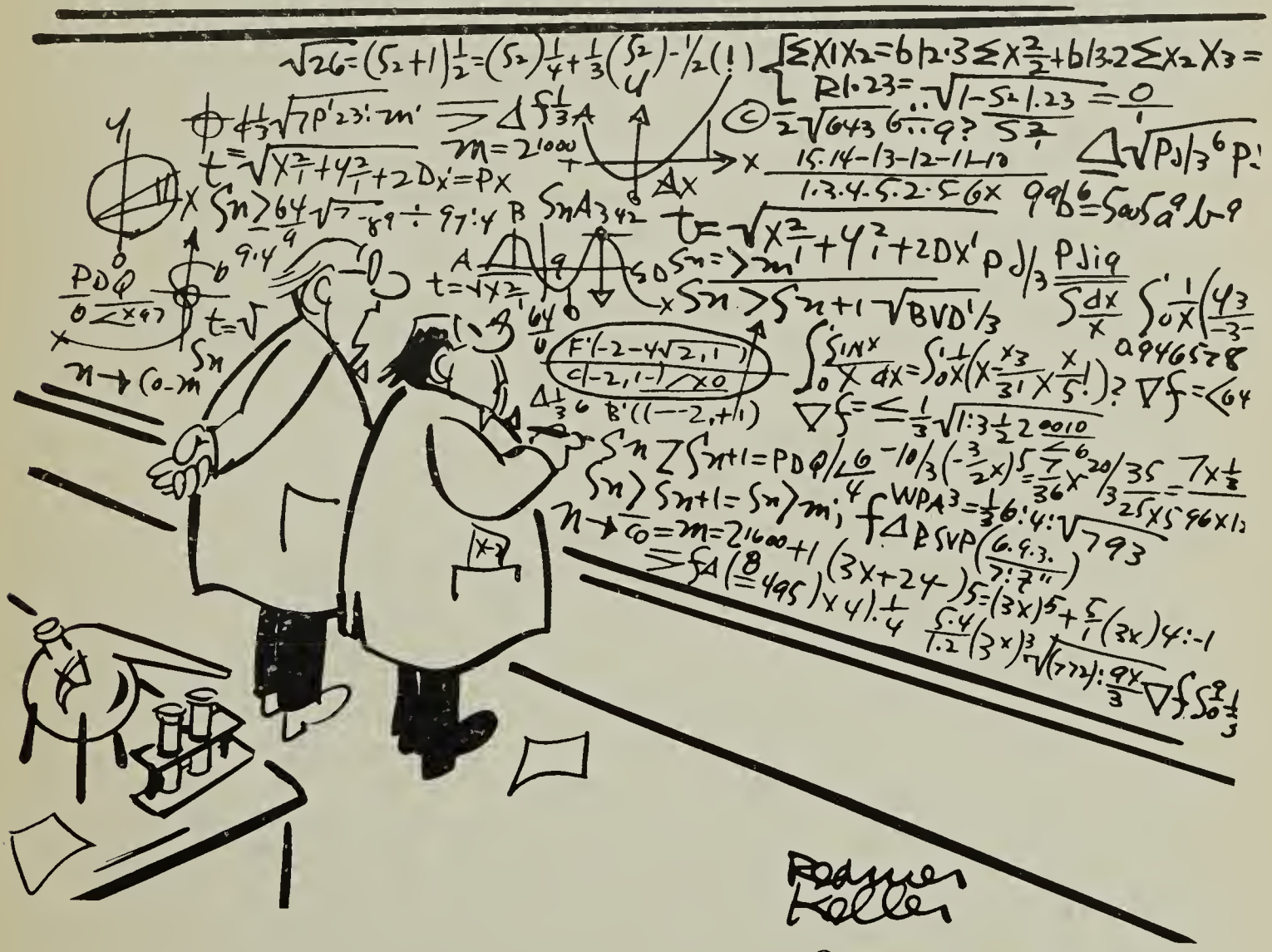
2. He is convinced of his superiority.

3. He claims that life itself is nothing but a gamble.

In Bergler's view, the gambler is an example of those people who, for unconscious reasons, counteract their own success. He considers the gambler to be a psychic masochist, an objectively sick person who is subjectively unaware that he is sick. The act of gambling itself is a denial of the reality principle. In this act, the gambler is expressing his neurotic aggression against those who have taught him the reality principle, in most cases his parents. In losing, the gambler is paying the penalty for his unconscious aggression.

According to Galdston, the alcoholic, the gambler, and the superstitious person, carry into maturity and incorporate within their adult personalities emotional and psychological dynamisms and relational configurations that belong to the preadolescent and childhood period. Piaget believes that the child's logic is precausal in quality and nature. For the child, causality is largely an extension of arbitrary intention, the fulfilment of the desire or the caprice of potent agents, human or otherwise. The alcoholic, the superstitious person, and the gambler have retained within their personality structure the early precausal patterns of comprehending and dealing with reality and experience. The gambler behaves as if he were still a child to whom gifts may come by mere solicitation or by teasing for them, as indeed is the case in the child's experience.

(Continued on page 10)



"So what if the odds are against me? Luck is on my side."

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

ST. LOUIS, MISSOURI: The nation's first detoxification center for persons arrested for chronic public intoxication has opened in St. Louis, Mo., according to Edward Dowd, president of the St. Louis Board of Police Commissioners. Persons brought to the 30-bed center are given a summons to appear in City Court on a public drunkenness charge if they leave before discharge. The summons will be dismissed at the time of discharge—a maximum of seven days and in most cases earlier.

Acute cases will receive round the clock care for two days, after which they will be put in an ambulatory section and will be required to attend lectures. The patients will be, at that time, interviewed by center specialists. Women as well as men will be treated at the center.

Col. Dowd said that if any law violation other than public intoxication is involved the subject will be arrested and processed according to present police procedures upon discharge from the center. (From the Florida **Reporter.)**

CHICAGO, ILLINOIS: The North American Association of Alcoholism Programs will hold its 18th annual meeting at the Sheraton-Chicago Hotel, September 24-28. Host agencies are the Illinois Division of Alcoholism, Department of Mental Health; Chicago Alcoholic Treatment Center; Chicago Council on Alcoholism and 15 Illinois agency members of NAAAP. According to **Concern,** a publication of Community Concern for Alcoholism, the local alcoholism program of Elgin, Ill., William N. Becker, Jr., assistant chief of the Illinois Division on Alcoholism, is general chairman of this year's meeting. George C. Dimas, executive director of the Oregon Alcohol Studies and Rehabilitation Section, is program chairman. The theme of the meeting will be "Alcoholism —A Community Problem."

Membership of NAAAP consists of the official alcoholism agencies of the United States and Canada.

ONE ANNUAL MEETING AGO: Attorney Peter B. Hutt of Washington, D. C., the attorney who presented the appeal in the history-making Dewitt Easter case heard before the U. S. Court of Appeals in the District of Columbia, speaking at the 17th annual meeting of the North American Association of Alcoholism Programs in Albuquerque, N. M., charged members of the NAAAP with the responsibility for providing the means for rehabilitating the chronic drunkenness offender. He noted, "The appeal I make to you this morning is far more important than the appeal I made to that court. For it is you, the representatives of the official state agencies charged with responsibility for public alcoholism programs, and not the courts, who possess the authority to realize the full potential of the Easter decision. And, conversely, it is you, and not the courts, who will bear the full responsibility if the Easter decision goes down in history as nothing more than a theoretically intriguing, but nevertheless meaningless, jurisprudential aberration."

Hutt charged these agencies with the responsibility of educating police, judges, prosecuting attorneys and correctional officials on the problems of alcoholism, the alcoholic personality, the disease concepts of alcoholism. "We do not need more elaborate conferences, large halls filled with experts giving speeches on theoretical concepts. We need man-to-man confrontations among public officials, without fanfare or publicity, in which practical solutions to pressing problems are worked out on a sensible basis," he concluded.

ALCOHOLISM LEGISLATION: The 1967 N. C. General Assembly funded in the "A" budget the usual alcoholism activities of the Department of Mental Health in education and treatment as well as the operation of two alcoholic rehabilitation centers, authorized by the 1965 General Assembly, which are to be built. In addition, $500,000 was appropriated for: (1) The establishment of a Division on Alcoholism within the Department of Mental Health to direct and coordinate departmental alcoholism programs at the local level ($100,000); (2) for local programs of education, treatment, and counseling and advisory services to alcoholics and their families or anyone directly affected by alcoholism ($250,000 to be made available to local governmental agencies on a dollar for dollar matching basis); and (3) building an alcoholic rehabilitation center in Mecklenburg County ($150,000 also on a one-to-one matching basis). Local ABC funds may now be used for research, and individuals may now plead chronic alcoholism as a defense to the charge of public drunkenness. The later law allows the court to retain jurisdiction over a person so acquitted for purposes of treatment up to two years. In retaining this jurisdiction, the judge may utilize one of several procedures including judicial hospitalization, referrals to private physicians, social or welfare agencies, or hospitals and diagnostic centers, or request an appropriate local governmental agency to work with the person and report back to the court. Another law provides a statewide penalty for a conviction of public drunkenness—either a $50 fine or twenty days in the county jail—and allows the repeater to be referred for treatment instead of prison. In addition to the above penalties, the repeater can be committed to the custody of the Commissioner of Corrections for not less than thirty days or more than six months. If the commissioner so chooses, he may authorize the person to be sent to a facility for treatment of alcoholism in lieu of prison.

Editor's Note: After the State Department of Mental Health was formed in 1963 by legislative action, the program known for many years as the N. C. Alcoholic Rehabilitation Program, and its educational work, was absorbed by the department, namely, through its Education Division. In the two years since the occasion for this article, other changes have taken place. The *Driver* decision of the U. S. Fourth Circuit Court of Appeals made it illegal to jail chronic alcoholics for public drunkenness in North Carolina. The 1967 General Assembly followed suit by allowing chronic alcoholism as a complete defense to the charge of public drunkenness, and opened the door to enforced treatment by allowing the judge to retain jurisdiction over a person so acquitted for purposes of treatment. For additional information on legislation, see *What's Brewing,* pages 8 and 9, this issue. Interim activity in the joint area of alcoholism-tuberculosis has included a workshop for eastern North Carolina co-sponsored by the Pitt County Alcohol Information and Service Center and the Coastal Eastern Area Tuberculosis Association. Also, the 1965 General Assembly added a nickel-a-bottle to the price of ABC store products in order to finance the building of alcoholic rehabilitation centers in eastern and western North Carolina. And, finally, came this year's legislation which includes, in addition to the above, funds to begin a Division on Alcoholism within the department and matching money for the building of an alcoholic rehabilitation center in Mecklenburg County. (For the reason for this note, see the article, "Some Similarities in Alcoholism and Tuberculosis Control Problems," pages 17 and 20, this issue.)

The alcoholic makes use of another precausality pattern, that of the denial of the unacceptable reality. To the child nothing is impossible, for in its world nothing obeys causal loss. The alcoholic, the superstitious person, and the gambler are to be viewed not merely as grown individuals embarrassed by the retention of some childish traits, but rather as sick individuals in whom the retention of preadult patterns is a symptom of some serious injury. These patients do not operate with childlish patterns in the world of the child, but with childish patterns in the world of the adult. Result: distortion and disfigurement. They suffered severe deprivations in their affect relations with their parents. According to Greenson, in the history of neurotic gamblers we find severe deprivation and/or overgratification in that childhood. From these psychopathological findings, Bergler draws the conclusion that the gambler is a misunderstood neurotic.

To the gambler, money is nothing but a token of his favor; it is not the aim of his gambling. He behaves as if he were bent on soliciting and teasing Fortune into smiling benignantly upon him and granting him her favors. Neurotic gambling can be understood as a compulsive acting out of a plea to surrogated figures (mother, father) for a show of favor, for the affirmative response to the questions, "Do you love me?," "Do you approve of me,?" "Do you think I am good, and smart, and strong?"

Bergler and Greenson describe the gambler as one who has regressed to infantile longings for omnipotence. Galdston is rather persuaded to consider him as one who has not successfully egressed out of the child's world of precausality. He thinks the primal injury has taken place in the early affect relations between mother and child, the father playing a secondary role. The triad alcoholism, gambling and superstition are conditions which are notoriously resistant to therapy.

According to Fenichel, the passion for gambling is a displaced expression of conflicts around infantile sexuality, aroused by the fear of losing necessary reassurances regarding anxiety or guilt feelings. As a rule, the conflicts are those centered around masturbation. In his view, the excitement of the game corresponds to sexual excitement; that of winning to orgasm (and to killing); that of losing, to punishment by castration (and by being killed.) Just as compulsion neurotics invent various kinds of oracles in their intention to force God to permit masturbation and to free them of their guilt feeling (which as a rule fails), the gambler, too, tempts Fate to declare whether it is in favor of his playing (masturbation) or whether it is going to castrate him. As in all conflicts around masturbation, here too, the activity serves as the scapegoat for the objectionable (hostile) phantasies of which it is the agent. The intensity of the conflict around getting the "supplies" again hints at an old fixation; besides, the anal element (the part played by money) also appears to be conspicuous. The importance of orality in gambling is repeatedly emphasized by Bergler.

Fenichel has to admit that all this is not sufficient to explain the specific passion for gambling. In its essence, gambling is a provocation of Fate which is forced to make its decision for or against the individual. Luck means a promise of protection (of narcissistic supplies) in future instinctual acts. But what is more important is that the typical gambler

consciously or unconsciously believes in his right to ask for special protection by Fate. His gambling is an attempt to compel Fate, in a magical way, to do its "duty;" however, gambling is a fight with Fate. The gambler threatens to kill Fate if it refuses the necessary supply and is ready, for this purpose, to run the risk of being killed. Actually, the unconscious masturbatory phantasies often center around patricide.

In honest gambling, the chance of losing is as great as the chance of winning. The gambler dares to compel the gods to make a decision about him, looking for their forgiveness. But even to lose (to be sentenced or killed) seems to him preferable to a continuation of the unbearable superego pressure. If winning in gambling means rebellion in order to get what is needed, luck is unconsciously looked upon as ingratiation for the same purpose.

Many impulsive actions tend to express not only instinctual drives but the demands of a severe superego as well. The gambler may eventually be ruined, the arsonist and thief ultimately be caught. Impulsive behavior often makes its appearance among moral masochists with an intense need for punishment. Qualitatively, there is no difference in this respect between such impulses and compulsions or perversions; many compulsions aim to satisfy the demands of the superego by means of punishment, and some exhibitionists feel tempted only when a policeman is in the vicinity. Quantitatively, however, there is a difference: the conflict with the superego more frequently dominates the picture in impulse-neurosis. The true gambler

"I've been using company funds to play the horses, and I can report a net profit of $18,926.00"

must eventually be ruined. This theme is illustrated by the fact that impulse neurosis, like manic-depressive states, frequently present a period ultimate between guilt-laden periods in which the superego apparently is inoperative.

Gambling and masturbation have another point in common, in that both are intended as a kind of play. The psychological function of play is to get rid of extreme tensions by the active repetition or anticipation of these tensions in a self-chosen dosage and at a self-chosen time. Masturbation in childhood and puberty, in this sense, is "playing at" sexual excitement, acquainting the ego with this excitement and preparing it for the ability to control it. Gambling, in the beginning, is thought of as "playing," in the sense that the oracle is "playfully" asked how it would decide in a more serious situation. Under the pressure of inner tension, the playful character may be lost. The ego can no longer control what it has initiated, but is overwhelmed by a serious, vicious circle of anxiety, violent need for reassurance, and anxiety over the intensity of this violence. The pastime becomes a matter of life and death.

Addiction Without Drugs

In the preceding pages, I have attempted to present some of the pathological features assumed to be characteristically found in the personality of the neurotic gambler. At least some of these features are being found in the personality make-up of the alcoholic and of the addict. According to the accepted definition of addiction, this is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated administration of a drug. Its characteristics are a compulsion to continue to take the drug and to increase the dose, with the development of psychic and sometimes physical dependence on the effects of the drug, so that the development of a means to continue the administration of the drug becomes an important motive in the addict's existence.

In recent years, we have become used to viewing addiction in a much broader scope. It is well known that the mechanisms and symptoms of addiction also occur without the use of any drug and thus without the complications brought by the chemical effects of drugs. There is the food addict, the reading addict, the love addict; and there is a variety of hobbies which tend to outgrow their hobby character and to evolve into an obsessive preoccupation, eventually becoming an absolutely necessary condition for well-being and protection against depression.

All the morbid impulses, as well as the addictions with and without drugs, have in common the fact that they are unsuccessful attempts to master guilt, depression or anxiety in their own way, mostly by activity. The same holds true for both gambling and drinking. Seen in this light, gambling takes the shape of another addiction. In our endeavor to learn more about the disease, addiction, which is so difficult to understand, I feel that it is of extreme importance to enlarge the scope of our investigation—which would mean including gambling in the realm of our studies.

Just as a side note, I would like to point out that a number of ex-gamblers, that is, persons who have succeeded in giving up their gambling addiction, have set up a society known as Gamblers Anonymous—an analogy with Alcoholics Anonymous and Narcotics Anonymous.

"Show me the obese patient who lost weight and still overeats or the alcoholic who recovered and just drinks beer and 'I'll eat your hat.'"

Foodoholics and Alcoholics

BY ROBERT S. SOLOMON, M.D.

MEDICAL authorities are continually pointing out the similarities between the disease syndromes of obesity and alcoholism. Not only are many of the psychological and physiological aspects similar in these two diseases, but, also, are the responses to and relapses in treatment. In most textbook descriptions of obesity and alcoholism, the words "food" and "alcohol" can almost be exchanged for each other in the context of the definition.

We find that both the obese and the alcoholic are "oral" people and that activities of their mouths serve as important functions to them. This serves as an emotional outlet to relieve their tensions and anxieties. They eat or drink when more nervous or worried, or when "idle, bored or tired." There is a natural tendency to comfort oneself with good food and drink. Many feel they "deserve" such activities as eating and/or drinking because of the hardships or circumstances of their daily activities. Thus, overeating or overdrinking becomes a reward to oneself—a self-presented "purple heart" for living.

Most statisticians consider alcoholism as Public Health Problem No. 4 in the United States. Nutritional experts, on the other hand, feel that obesity is a greater jeopardy to health. We know that the obese have a greater tendency for heart disease and a higher incidence of strokes. They have an increased incidence of diabetes, leg phlebitis, hernias, and they are poorer surgical risks. The fat in-

This article is reprinted by permission of the author and *Lifelines,* a publication of the South Carolina Commission on Alcoholism. It is based on a series of three newspaper articles published by *The News & Courier* of Charleston, S. C. Dr. Solomon is in the general practice of medicine in Moncks Corner, South Carolina. He is chairman of the S. C. Medical Association's Committee on Alcoholism and Drug Addiction, and vice-chairman of its Public Relations Committee.

dividual perpetuates his fat by further guilts and anxieties from being fat. On the other hand, the alcoholic has his stomach trouble, hangovers, his neuritis, surgical hazards and self-induced liver disease and he, too, perpetuates his disease by further guilts and anxieties from more drinking. It is interesting that food and alcohol are two products in which self-indulgence relieves the acute manifestations of their respective diseases but furthers the overall disease process.

In the United States, one in every fifteen persons who drinks alcoholic beverages, develops alcoholism. There is a much higher incidence of obesity, but, of course, there are more people who eat than drink. Overeating is accepted in public places. It is inborn and we are forced from birth to overeat. With our first cry, a bottle was slapped in our mouths and since then we have heard "don't waste food," "eat what is set before you," "be pleasantly plump," etc.

Alcohol, on the other hand, is the "forbidden juice," at least up until proper age, or cocktail time, and then our host sticks a martini in every hand and we must be a "jolly good fellow" with olives popping out one ear and hors d'oeuvres the other. Society persuades us to overindulgence of food and drink and then frowns when we become addicted to either. Both "addictions" are quite similar.

The grossly obese person does not simply overeat. In most cases, he is a compulsive eater and not unlike the compulsive drinker. There are subconscious reasons that induce overindulgence and this excess may mask or substitute for many emotional problems. Food and drink are used to combat anxiety and loneliness, as well as escape from them.

Just as many psychological factors are similar in these two diseases, so are many of the physiological mechanisms—and they are equally complex. The obese, in order to maintain lost weight, must learn new eating habits and continually diet, or weight is readily regained. The alcoholic must practice total abstinence and forego even the social drink or his metabolic mechanisms are re-triggered and he reverts to his dependence on the alcohol even after years of abstinence.

To achieve an effective treatment program in the foodoholic or the alcoholic, we cannot scare them with fears of medical complications. The punitive approach seldom works in either illness, since we are dealing with patients who are already over anxious and such threats make them still more anxious and does not accomplish the end result. It is equally wrong to stress the rewards of treatment since patients become disappointed if they do not appear rapidly and thus there is a tendency to have relapses.

The most success in treatment is attained when the patient can develop proper attitudes and provide a suitable substitute for food or drink. The prime atmosphere for treatment is a healthy doctor-patient, patient-family and doctor-family relationship. The patient must have a sincere desire to control his "addiction." He must have proper attitudes and be guided in his approach to the overall problem.

Just as there must be controlled abstinence in the case of the alcoholic, there must be controlled diet in the obese. Medications under supervision of the doctor can be valuable complements to treatment in both illnesses. Emotional factors must be dealt with through psychiatric treatment or close relation-

ship of patient and family physician.

Group therapy organizations as Obesity Anonymous, Take Off Pounds Sensibly or Alcoholics Anonymous have been the most successful programs in affording effective treatment with fewer relapses. These groups stress dependence on a power greater than oneself, allow the individual to admit his shortcomings and think positive on his problems, and promote a general understanding among persons with similar problems.

Patients with either condition should avail themselves of all avenues of therapy, since treatment success is recovery, not cure, and the relapse rate in both diseases is high.

Granted, there are individuals who "eat like a horse" and never gain an ounce compared with another who can walk by a table and gain a pound, but we find metabolically, the former expends this energy from a large calorie intake whereas the obese stores fat rather than burning it up as energy. Simply, the obese has a metabolic defect which interferes with his intake-output ratio. He perpetuates his disease by further increasing his intake, and lowers his physical output. He becomes addicted to more food and less work. He becomes a foodoholic.

Thus, new eating habits with controlled caloric intake, coupled with adequate physical activity, is the answer for long-term recovery for the foodoholic. Diet alone is not enough.

The overweight individual is many times the compulsive person. He is "oral." He has anxieties coupled with guilts. He rationalizes. He justifies his intemperance in food and drink. He reduces his calories at breakfast and catches up at a midnight snack. He uses saccharin to appease his conscience and pie a la mode to appease his hunger pains. He fattens himself up "for the kill" by increased carbohydrates and less physical activities. The progressiveness of his illness is sure and insidious.

He must understand his illness. He must attain a healthy attitude toward his reduction and maintenance program. With proper attitudes, he must establish other outlets for his tensions and anxieties.

Recovery for the foodoholic is controlled and continuing low calorie diet, whereas the hope for the alcoholic lies in complete abstinence. Calories do count, whether carbohydrate, protein or fat. Alcohol is alcohol, whether whiskey, beer or wine. Show me the obese patient who lost weight and still overeats or the alcoholic who recovered and just drinks beer or a social drink and "I'll eat your hat."

Of course, alcoholism presents a vastly greater public health problem than obesity because we are dealing with a true drug addiction which has progressive socioeconomic as well as progressive physical and mental complications. The obese slowly eat themselves to death with a heart attack or stroke while the alcoholic's problem involves the family, job, friends and then individual self-destruction physically.

We have had alcohol since the first grape fermented and alcoholism since the first man drank it. But what happens in this disease where the man can drink "socially" ten to twenty years and suddenly finds himself so dependent on the drug that it comes first, before self and others? He is "oral" and compulsive. He is anxious, perhaps neurotic. He may be a Ph.D. or a high school dropout, yet once he develops the alcohol syndrome, there is no rhyme or reason for his actions or activities.

Some medical authorities believe

(Continued on page 23)

Some Similarities in Alcoholism

If tuberculosis could start with so little and come so far in 60 years, how much farther should alcoholism be able to go in the same length of time with all the facilities and know-how that are at its disposal today?

BY LILLIAN PIKE

This article is adapted from a talk given at a meeting of the Alcoholism Programs of North Carolina in May of 1965 at N. C. Sanatorium at McCain. Its author is alcoholism publications editor, Education Division, N. C. Department of Mental Health and a former field consultant and news editor with the North Carolina Tuberculosis Association.

ALCOHOLISM and tuberculosis are both old. They have been with us a long time. There is evidence of the existence of tuberculosis before recorded history began. Certainly alcohol was discovered by man long before he learned to read or write. The earliest written records do describe drinking and some of the attendant effects of excess—drunkenness, immoral conduct, etc.

The first similarity is that alcoholism and tuberculosis *are* comparable as age-old problems of mankind.

Through the ages and on up until the present time, both alcoholism and tuberculosis have brought immeasurable suffering to untold millions of people—not only to the victims themselves but to their families, friends, associates and society.

Both are among the illnesses which have been labeled "socially unacceptable" by society through ignorance, fear, prejudice and superstition. Thus, their victims have had the burden of social stigma to bear in addition to the illnesses and their concommitant effects.

Fortunately, this is not as much true of tuberculosis now as it is of alcoholism and some of the factors which helped bring about this change will be mentioned later.

Just remember for the time being that it hasn't been too many decades ago that the tuberculosis patient was literally hidden away in the back room and left to die or surreptiously "sent away" on a long vacation, depending upon the affluence of the family. Granted, that the alcoholic as he progresses through the various stages of alcoholism is a little harder to hide *literally,* certain well documented cover-up and protective techniques employed by families, depending upon their affluence, are somewhat analgous—at least the intent is similar.

When I entered the tuberculosis field in 1950, for instance, local tuberculosis associations were vigorously attacking the problem of gaining community acceptance for recovered patients returning from the sanatorium, and their families. So great was the social ostracism that many tuberculosis associations were organizing "ex-patient" clubs for social contact. Employers, church and civic clubs were targets for soliciting understanding and acceptance for ex-patients, the chief aim being to break down the fear which made them non-accepting. The community had to be

taught that the treated tuberculosis person was safe to be with, safer even than the general population.

Ten years later, in 1960, when I left the tuberculosis field and came with the *Alcoholic Rehabilitation Program, I heard much the same refrain. "The alcoholic is a sick person. He needs help and is worthy of help. The alcoholic can't be cured but his illness can be arrested. He can recover. Alcoholism is a treatable disease." Need I go on? There was a new note in the refrain however. The stumbling stone to acceptance of the alcoholic or even helping him was not so much fear as the feeling that "alcoholics are no good anyway so even if they could be helped they aren't worth helping."

These illnesses are similar in other ways. Both are chronic diseases requiring long-term treatment and rehabilitation, with the patient being subject to relapses unless prescribed regimens are followed.

They are both costly, socially and economically. The victims are likely to be wage earners with families depending upon them for support.

In the case of tuberculosis, when support is not forthcoming from some other family member, the family is eligible for public assistance while the patient is under treatment and until he is able to return to work. The alcoholic whose family is receiving such help is probably in jail or prison for nonsupport, public drunkenness or some other offense, or has deserted his family.

Again, the social and economic costs of tuberculosis are not so great as they once were. The treatment period is shorter. With better treatment methods, patients are coming out of the hospital *alive* and in a good enough physical condition to enable most of them to return to their usual jobs. Patients who survive tuberculosis now are not as severely crippled economically, socially and physically as they once were.

You may be thinking that there is one major difference. Tuberculosis has a specific cause, the tubercle bacillus, while the etiology of alcoholism is embedded in a myriad of factors—sociological, psychological and physical.

Let's examine this statement.

It is true that tuberculosis cannot exist without the presence of the tubercle bacillus, but neither can alcoholism exist without the involvement of alcohol. Consider this:

After some 60 years of concentrated tuberculosis control efforts during which the death rate has been phenomenally reduced, case finding and treatment methods refined, an epidemiology developed, the incidence and prevalence considerably reduced, recent tuberculin testing surveys indicate that a third of the entire population is infected with the tubercle bacillus. Yet, only three per cent of those infected are ever expected to get the disease.

Does this not sound a little similar to the statement that there are 70-80 million people in the United States who drink, but only 5-6 million are alcoholic. Mathematically the difference is that only 3 per cent of the people who are infected with the

nd Tuberculosis Control Problems

*(See Editor's Note, page 9).

tubercle bacillus are expected to come down with tuberculosis, while 7½ per cent of the people who drink are already alcoholic.

Obviously *something* other than the tubercle bacillus is involved in a person's getting tuberculosis. What *is* this something? This question leads right back to a myriad of sociological and psychological factors of a non-specific nature which you will recognize as being similar to the description of the etiology of alcoholism in regard to factors *other than alcohol.*

Cultural factors such as a person's economic status, mode of life and attitudes are thought to be involved in a person's breakdown with tuberculosis as well as psychological factors such as the person's personality and capacity for coping with the stresses of every day life. Please note that alcoholism has been described by many authorities as "a way of life, a method of coping with the stresses of every day living."

Probably this is the weakest link in the tuberculosis control program. The influence of sociocultural and psychological factors is recognized and talked about but less has been done in this area than in others. The neglect of this area is certainly germane to a consideration of the existence of alcoholism and tuberculosis in the same person, though it relates also to the tuberculosis patient who is not an alcoholic.

Particularly, neglect of treating the tuberculous alcoholic's alcoholism is incompatible with the goal of tuberculosis eradication from a very practical standpoint—breaking the chain of infection.

There is no doubt in my mind, however, that something will be done. Once the people in the tuberculosis field commit themselves to an admission that a problem exists, it is almost inevitable that they won't rest easy until a solution is found. I think that this breakthrough has been made. Our presence here today is an indication that it has. There are others.

During the 1950's, for instance, one of the first medical talks on tuberculosis that I heard was oriented to the statement that "the patient is more than a pair of lungs on a pair of legs" implying that the "total person" should be treated. There was also much discussion about recalcitrant patients who were defined as trouble makers—those who raised cain on the wards, were uncooperative, got drunk, or left the hospital against medical advice. The latter were known as AWOL'S which was defined as "after women or liquor." Alcohol was mentioned frequently in connection with recalcitrancy, but it was not until around the middle of the decade that anyone suggested that a second illness, alcoholism, might be the basis of the problem.

Meanwhile those who were working in the area of alcoholism had observed among alcoholics a phenomenon which they called "symptom swapping." Alcoholics, or some alcoholics, were prone to have other serious conditions such as ulcers and tuberculosis, but not at the same time. When the ulcer was active, the drinking ceased, and vice versa. Since, or in more recent years, sanatorium personnel have identified persons with tuberculosis who made "good patients" in the hospital, were cooperative in treatment and made a good recovery, only to go back to their respective communities, resume drinking, have a relapse, and come back to the hospital thereby starting the process all over. This is in great contrast to the recalcitrant-type problem drinker who is obvious to all, but, nevertheless, is a mani-

festation of tuberculosis and alcoholism in the same person.

Once I heard a sanatorium man offer a unique solution to the problem of patients drinking in the hospital—particularly the older men whose disease was not responding well to treatment and the chances were that they would be in the hospital a long time. He suggested setting aside an area in the hospital for a lounge and bar where whiskey would be served to these men—just one or two drinks, of course! Having become more acquainted with alcoholism and the philosophy and slogans of Alcoholics Anonymous, I've often wondered if this was ever tried and what the results were. One of the slogans of A.A. is "One drink is too many and a barrel is not enough" —if you are an alcoholic.

A number of events have transpired which indicate the beginning of a "meeting of minds" among forces chiefly interested in alcoholism and those chiefly interested in tuberculosis. Here are some of them:

In 1955 Mrs. Marty Mann, executive director of the National Council on Alcoholism, was invited to speak at the annual meeting of the National Tuberculosis Association. In attendance were staff and board members of the North Carolina Tuberculosis Association.

In February of 1960, Dr. Norbert Kelly, associate director of the North Carolina Alcoholic Rehabilitation Program, was invited to conduct a session at the annual program conference of the North Carolina Conference of Tuberculosis Workers, the first formal introduction to alcoholism that these workers had had. Enough impression was made that "Alcoholism and Tuberculosis" was selected as the theme for the annual Regional Tuberculosis Control Conference to be held later that year—to which all of the southern states are invited—of which the North Carolina Tuberculosis Association is a co-sponsor along with other North Carolina agencies.

Since the 1960 TB control conference, two representatives from North Carolina sanatoriums have attended the Yale and Rutgers Summer School of Alcohol Studies on scholarships provided by the North Carolina Alcoholic Rehabilitation Program. At least two of the sanatoriums have invited A. A. members to form groups within the hospitals, and one has conducted staff training sessions on alcoholism.

Why all this detail? First, it illustrates how information and ideas are transmitted in a strong voluntary health movement—in this case from national to state to local. Secondly, it illustrates the fact that it takes a lot of time and talk to gain recognition for a problem (in this case five years) and we must not despair when action is not immediately forthcoming. And finally, the action stage may have a slow beginning but it *will* reach a point of acceleration.

I believe this point is near. With enough encouragement and help from the Alcoholism Programs of North Carolina in passing along knowledge and know-how in working with alcoholism, I think you will begin to see an acceleration of effort in behalf of the tuberculous alcoholic.

Since at this point in time I have worked ten years in the tuberculosis control movement and five in alcoholism, I make no apology for this presentation's being twice as oriented to tuberculosis as to alcoholism. Incidentally, the comparative ages of the two health fields at this point in time in North Carolina are 59 for tuberculosis—dated from the be-

ginning of *organized effort*—and 16 for alcoholism. I think this age differential qualifies tuberculosis to speak from experience to alcoholism as a parent to a teen-ager. Actually, the tuberculosis control movement was the *first* of its kind and, therefore, is probably more of a granddaddy to the teen-ager than a parent in experience. Nevertheless, before I sit down, I wish to enumerate those principles and approaches which I believe the teen-ager, or alcoholism control movement, *must* borrow from the granddaddy, or tuberculosis control movement, if it is to succeed in alleviating alcoholism:

1. To constantly keep in mind that in dealing with an illness as serious, complex and widespread as alcoholism nothing less than "all out mobilization" can do anything more than put a dent in efforts to solve the problem. Zeal of this sort has stood the tuberculosis control movement in good stead and even unto this day must be maintained *if* the progress made against tuberculosis is to be maintained.

2. Alcoholism, like tuberculosis, is a public health problem. Therefore the alcoholism control movement must adopt, and adapt to its special interest, and utilize to the fullest the tried and proved *public health approach* to combatting a public health problem. Do it and it is sure that the *movement* of the alcoholism control movement will be *forward.* Don't do it and the movement will flounder. A good start in this direction would be to make alcoholism a reportable disease. This would enable case registers to be established and, consequently, make possible better epidemioloical study and case follow up. Then, on the basis of the best knowledge available, promote and establish education, case finding and treatment programs with appropriate rehabilitation and follow-up.

Particularly, in the controversial area of enforced treatment, alcoholism might consider the experience in tuberculosis: When a case of tuberculosis is diagnosed today, regardless of whether it is made by a private physician, a health department, or a hospital, a unified attitude is expressed to the patient—one of expectation. He is expected to get specialized treatment. He is expectd to go to the sanatorium if inpatient treatment is recommended. He is expected to protect his health, his family's health, and the community's health in this way. He is told exactly what his condition is, what treatment he needs, where he can get it, and who can help him. The expectation, on all sides, is that he *will* get the necessary treatment and, though he may refuse, he usually does what is expected of him.

There is no law in the statutes which states that having the symptoms of the disease, tuberculosis, is a crime, as it is with alcoholism.*

When tuberculosis is diagnosed, the patient legally has the choice of accepting treatment in a sanatorium, accepting treatment at home (although this is not often recommended), or not accepting treatment at all. If he chooses the latter, however, he is on shaky ground for he may die. If he lives, he must abide by certain health laws which pertain to communicable diseases. Basically, he must isolate himself so that he does not endanger the lives of others by exposing them to his *known* communicable disease. If he doesn't follow the rules of isolating himself from his family, from the community, then he may legally be declared a public health menace and *hospitalization,* not *jail* or *prison* as is the

*(See Editor's Note, page 9).

case with the alcoholic, can then be forced upon him.

3. Keep your sights, and insights, on education as the *basic underlying function of alcoholism control* but, more particularly, as the main function of the *voluntary* or *lay* aspects of the alcoholism control movement. As Dr. Edward L. Trudeau said in his inaugural address as the first president of the National Tuberculosis Association (in 1904), "The first and greatest need is education, education of the people and through them education of the State . . ." This was just a promise then, but it is a fact now. Adherence to this basic principle is a proved method of meeting needs that continually change with the times and as new knowledge is gained. Stated another way, it is the same as saying, "Seek ye first education and all these things—cooperation, legislation, facilities, personnel—or the tools neded to do the job will be added unto you." And it works, as health problem after health problem has succumbed to this approach.

4. Accept, since it has been proved over and over again, that no disease of the public health variety will ever be controlled from the top (be it national or state) and neither can any community (be it state or local) hope to be self-sufficient. It takes concerted effort at all levels. There are certain tasks and functions that are best performed locally. Others are best performed at the state and national levels. Certain tasks also are best performed by volunteer or lay people and others by professional people. Some programs are better supported by voluntary or lay people with voluntary funds. Others lend themselves better to support by an official agency and the tax dollar. What these divisions are are no mystery today. They have been spelled out over and over again throughout the past 60 years by other health movements as well as the tuberculosis control movement. They can be ignored by a relative newcomer but they do not have to be sought out or defined. There is a need for both voluntary and tax money as well as their respective agencies.

5. We do not ever know enough or have enough knowledge. The establishment of research programs in alcoholism and their continuous support is imperative.

6. Cherish the voluntary board and the voluntary board member for herein is the greatest strength of any health movement and the only "grass roots" checks and balance for its official counterpart. Strengthen *it* and *him* in every way possible and help *them* to remain as free as is humanly possible. Remember, the tuberculosis control movement which today encompasses a vast complex of official and voluntary agencies was in the beginning in the hands of the interested, zealous and capable volunteer. It was through his efforts that tuberculosis control was brought to its present stage of progress. There is an area of responsibility for the official and the voluntary agency and they complement each other rather than compete.

In conclusion, I would like to pose one final question: If the tuberculosis control movement could start with no facilities and no know-how and come this far in 60 years, how much further should the alcoholism control movement be able to go in the same length of time with all the knowledge, know-how and facilities that are at its disposal today? *Will* those who are interested take up the challenge? The course has been charted. It remains only to be followed.

THE PSYCHODYNAMIC ASPECTS

CONTINUED FROM PAGE 3

lieves the pain of tension and anxiety. This immediately implicates cultural factors, since it appears essential for the development of alcoholism that the culture be permissive of and supportive to the use of alcohol as a pain-relieving mechanism. This, in turn, leads to a consideration of the biological factors contributing to any addictive process upon which the psychological and cultural factors are superimposed and with which they interact.

If one abstracts from these theories certain generalities, as above, and applies them as part of a framework involving cultural and biological theories, one is able to extract many meaningful implications for working with the alcoholic.

For example, what are some of the things we can expect to see in working with alcoholics (as patients, clients, parishioners, parolees, etc.) with which we must be prepared to deal if we are to be effective?

1. Alcoholics are apt to have an unrealistically high level of aspiration accompanied by comparatively limited achievements, creating many problems for the therapist or counsellor in redirecting activities on a more realistic level.

2. They show poor restraint over impulses, and frequently get into difficulty over this, which leads us to feel that they are poorly motivated and don't really want to get well.

3. Their relationships are frequently unstable and poorly linked to others, with a marked tendency to withdrawal—including withdrawal from a helping relationship.

4. They are often self-centered and have a great deal of difficulty in focusing on the needs of others.

5. They show wide, poorly controlled mood swings.

6. And many times, most distressing of all to the helping person, the alcoholic shows marked feelings of omnipotence—an absolute conviction that disaster cannot affect him. It is indeed baffling to others how anyone obviously damaging himself and undermining his health, career, domestic situation, and future can feel so omnipotent. It is apparent, in the face of this, that lecturing at, or intellectualizing with, the alcoholic about his alcoholism is a fruitless task.

What guidelines or principles can we abstract for working with the alcoholic in a variety of helping relationships?

1. The tools of the helping process may vary considerably but there is general agreement that the goal of abstinence must be central to any program.

2. The massive use of denial and omnipotence must be dealt with. "Reaching bottom" often accomplishes this, but it behooves us to find other means of bringing about the same result.

3. One must recognize the extreme sensitivity of the alcoholic to moral indignation on the part of the helping person in relation to alcoholism; thus, in a sense, one's "own house must be in order."

4. Because of the nature of the emotional patterns and reactions present in alcoholics, most of them are more responsive to group therapeutic experiences (including Alcoholics Anonymous) than to an intensive individual approach such as psychoanalysis.

5. The strong dependency needs of the alcoholic cannot be ignored or rejected, but must be met in a variety of ways, if one is to develop a sustained relationship, because of the alcoholic's sense of estrangement

from and distrust of people. Related to this dependency is a trait of passivity, which often is concealed behind a great deal of aggressive "activity."

6. The alcoholic must be helped in dealing with his environment, including the development of a more realistic level of aspiration.

7. Because, in most instances, the alcoholic is involved in a web of mutually destructive interpersonal relationships, it is usually necessary also to work with those closest to him.

8. Most important of all, there is no one right approach to the problems of the alcoholic. There are, rather, a variety of approaches. Some are more suitable to the needs of certain alcoholics than others.

Further, one might examine what factors within ourselves, in our relations as helping persons to the alcoholic, might interfere with our effectiveness, aside from ignorance, moral compunctions, prejudices, etc. Briefly, one needs to be concerned with:

1. One's own need for success, as it is obvious that recovery from alcoholism is marked by many frustrations, relapses, and failures;

2. One's ability to meet the demand of extremely dependent persons and not become either overwhelmed or rejecting;

3. One's own ability to set realistic levels of aspiration in treatment goals for one's patient or client;

4. One's ability to accept hostility and rejection and still maintain a supportive relationship.

Although what has been presented in this article is only a cursory review of some of the clinical psychiatric aspects of alcoholism, these are some of the elements which may prove helpful to anyone working in this field.

FOODOHOLICS AND ALCOHOLICS

CONTINUED FROM PAGE 15

that the breakdown products of digesting alcohol cause a sensitivity to certain body cells with an increased production of these cells and the enzymes that stimulate them. Repeated alcohol toxins activate these enzymes and overstimulate these newly produced cells. Once this cell-enzyme reaction is formed, it is permanent and can be reactivated with any continued or future stimulation. This accounts for many of the symptoms of overdrinking and explains why an alcoholic cannot resume drinking after years of abstinence and why "binge" drinkers have complete relapses after months of being "on the wagon."

The same psychological mechanisms seen in the obese (e.g. guilt, tension, escapism, anxiety) are functioning in the alcoholic, but they are of greater magnitude and are rapidly progressive.

The prerequisite for successful treatment of the alcoholic is for him to understand that his body cannot tolerate alcohol. He must admit he is powerless over the drug. If he could do it himself he would not have the problem. His attitude concerning his illness must be healthy and he must understand the nature of his disease. He must avail himself of proper medical management and free himself from the vacuum in his psyche resulting from environmental and physiological changes.

Alcoholics Anonymous, through its group therapy, has molded these attitudes of treatment through its Twelve Steps to Recovery, the concept of the Higher Power and individual powerlessness over alcohol. Here again, persons with similar problems have been able to share

(Continued on page 31)

WHY DO THEY HAVE TO SUFFER SO LONG?

BY
THE REV. VERNON E. JOHNSON

Data from the case studies clearly indicated the usefulness, even necessity, of some form of intervention by those around the alcoholic.

Published by permission of the author, this article combines three of four articles written, and printed in pamphlet format, for the purpose of presenting data obtained in a series of case studies by the Church's Action Program. The Rev. Johnson is chaplain and director of The Johnson Institute, Minneapolis, Minnesota, a non-profit charitable foundation which provides treatment and other services in the area of alcoholism similar addictions, and related problems.

MOST people today assume that nothing can be done with the alcoholic with regard to arresting his illness until he or she is "ready." Even many people who have seen numbers of recoveries as well as those who have themselves experienced recovery often will shrug off a suffering alcoholic's resistance to help with the statement, "He just hasn't hit his bottom yet." This seems to imply that the condition must be allowed to progress until its victim in some spontaneous fashion acknowledges that he does indeed need help! His difficulties, physiologically, economically and/or socially, must become so severe that even the most stubborn and hardheaded alcoholic can no longer deny their connection with his uncontrolled and unpredictable drinking pattern. Most treatment in the past has begun at this level. The opinion persists that here is the only place it *can* begin, however inhumane or cruel this may be.

More recently, however, new insights have cast real doubts upon the necessity for such prolonged suffering. A recent study of patients at Willmar State Hospital indicated, for example, no significant difference in the number of recoveries between that group which had come voluntarily to the institution and those who had been committed there. Likewise, studies of the programs and populations of "halfway houses" indicate that those whose illnesses resulted in the more severe physical, economic, and/or social disorders do have more difficult and prolonged recovery processes. On the other hand, evidence has accumulated which indicates that where physical health has not broken, where jobs are not lost, where families have remained intact, alcoholics have tended to recover more often and more

quickly.

The answer to, "Why do they have to suffer so long?" now seems to be that they *don't* have to suffer that long at all, and they shouldn't.

A series of case studies made by the Church's Action Program in 1964-65 among recovered alcoholics asked the questions, "What events and which people caused you to realize and admit that you needed help? How did they do this? What events or people, in your opinion, were not helpful but rather prolonged your inability to recognize your illness? Why?" Eighty per cent of the group studied were business and professional persons or suburban housewives, although a wide economic and social range was present in the other twenty per cent. Recovery periods varied from a few months to a decade or more. Conclusions from the data gathered can be summarized in two categories:

1. The need for greater knowledge of the *nature* of the illness by those around the alcoholic.

2. The application of this knowledge by those meaningful persons in a direct, consistent, objective, and non-judgmental confrontation of the alcoholic with the reality of his condition. Spouses, clergy, doctors, employers, other members of the family, and other "helping" disciplines singly and collectively are listed as those who brought about first admission of the illness. "If only they had known more about the illness, so much pain could have been avoided" is one of the most repeated phrases of these interviews.

Historically, the alcoholic has been viewed as a "weak-willed" or "poorly motivated" individual. He is thought to be one whose values have become thoroughly egocentric or are entirely absent. He doesn't really care about others or even about himself. He drinks inappropriately, unpredictably, too much, constantly, or compulsively. To those around him, he is at once a loveable, hateful, energetic, lazy, thoughtful, self-centered, productive, useless, kind, and angry individual who is becoming more and more impossible as time goes on. Traditionally, the church has called him one of her most obvious and persistent sinners, while to medical science, he has been a time-consuming, if not a hopeless enigma.

More recently, *medical doctors and clergymen have begun to describe him as a sick person.* In fact, this is considered to be a significant breakthrough.

Nevertheless, one inescapable conclusion drawn from the data provided by the series of case studies among recovered alcoholics was that while the term, illness, with reference to alcoholism, has gained rather widespread usage in the general public (93 per cent of the Parish Profile), time-honored misconceptions remain firmly entrenched in these same people's minds. "All he (or she) needs to do is to control his drinking, or, better yet, cut it out entirely!" well describes what is the common attitude.

It is this attitude which prevents or vitiates many attempts of persons around the alcoholic to confront him with the reality of his condition, according to virtually all the persons involved in this study. Many persons around the alcoholic still moralize, accuse and remonstrate. They speak of the "illness" and yet do not understand the dynamics of compulsive behavior with regard to the use of a chemical. This unconscious rejection of the illness concept by the "helping" persons continues to obstruct their ability to be helpful. In fact, the study indicated that con-

frontations at these levels were perceived as punitive or sympathetic and actually caused unnecessary delays of proper recognition of the disorder.

The recovered alcoholics recalled being told repeatedly such things as: "If you loved me or the children, you would quit."

"Have you no pride in yourself."

"With all these terrible things that have happened, any person with even an ounce of willpower would never take another drink as long as he lived."

Their reaction was just as repeatedly to enter more deeply into feelings of self-pity and resentment. "If only my husband (or wife, pastor, doctor) had known *something* about addiction, he could have helped me so much more," the subjects of the study agreed in retrospect.

It is one thing to call a condition a sickness, and quite another to understand the nature of the addictive process and self-deluded dilemma of the addicted person. One recovered alcoholic put it succintly by stating, "My wife thought I could if I would but that I wouldn't; and I knew that I would if I could but I couldn't!" Here, in a few words, are the poignant and shattering tensions within family and social interpersonal relationships. Here, too, is the terrifying and bewildering characterological conflict of the addicted person. On the one hand, society is calling the alcoholic sick and behaving towards him as though it were entirely up to him to make himself well. On the other hand, the alcoholic is denying that he is sick but discovering that he cannot help himself. "There is something totally unreal," observed one recovered alcoholic, "about expecting a person out of touch with reality to know by himself how unrealistic he is." Such attempts to "help" were described as "confusion compounded."

"My wife thought I could if I would" is an attitude concerning which all who attempt to relate to the alcoholic at the level of intervention must examine themselves quite honestly. Throughout the study there was agreement that attempts at confrontation which were not helpful were those where, even though lip service was being paid to the illness concept, the alcoholic perceived that the statements were actually accusative or judgmental. (The alcoholic, it should be noted, seems especially sensitive to such moralizing attitudes. His finely tuned radar very quickly picks them up as rejection.)

Shallow Understanding Revealed

Put in another way, most confrontations were described as superficial because they revealed a very shallow understanding of the dynamics of alcoholism. Rather than being required to accept their condition as a progressive, debilitating, even deadly disorder, involving their total lives, the subjects recalled being told frequently something like, "Maybe you ought to quit drinking, you don't seem to be able to handle it like you used to." Their reactions were equally superficial during that long period of time when, in point of fact, their conditions were progressively deteriorating. Denial and rationalization came easily. "I can handle it and just as well as before, or as well as you do," or "I can quit anytime I want to, and I have, many times in the past."

As long as the alcoholic's condition was related in these confrontations *only* to the times, or quantities, or even behaviors *connected with drinking per se,* most of these people remembered no serious threat to their

defense system. Severe feelings of embarrassment, even deep remorse, could be worked through successfully again and again on the premise that "next time the drinking pattern will be different." Many described an almost constant facade of rationalizations and projections as relatively acceptable to themselves. "Doesn't everybody make similar mistakes?" They could remain relatively comfortable because *they did not see themselves as essentially different from most normal or well people,* who also went off the deep end occasionally and had their troubles too.

On the positive side, confrontations which were perceived as helpful included the following basic elements:

1. *Alcoholism is indeed an illness which is progressive, crippling, even deadly.* Here a wide variety of attitudes were described as possible and useful so long as they conveyed that the confronting person did in fact believe the alcoholic to be sick. These attitudes ranged from frank bewilderment to deep insights into the dynamics of addiction. One woman, for example, related that her husband had told her very directly one evening that he was baffled, but that knowing her, she *had* to be sick to behave like this, and that he was going to read everything he could get his hands on regarding alcoholism. A doctor was quoted as saying, "Medically, you have received what *I* can do, but there is much more to this illness. The rest of the treatment you can get at this certain treatment center and at Alcoholics Anonymous. My advice is to go to both."

The study corroborated the observation that nearly always the last to accept alcoholism as an illness is still the alcoholic himself. Spouses and immediate relatives, however, continue also to be very slow in identifying the disorder as an illness. Their deep emotional involvement was listed as the chief reason for being blocked from objectivity in evaluation of the alcoholic.

2. *Outside intervention is nearly always necessary* because of the nature of the illness. Those persons who most successfully broke through the defense system of the suffering alcoholic were those who, by intuition or experience, accepted as fact that addiction by definition is a condition where "normal" willpower is inadequate to control the use of the chemical. They knew, also, that the effect of alcohol, while it is being ingested, is to reduce further the function of even "normal" willpower. Most important, however, was that they realized the alcoholic's defense system had become so highly developed in attempting to deal with an uncontrollable behavior that a large measure of self-delusion was now present. They saw that the alcoholic was incapable of realistic and objective self-evaluation. One alcoholic said, "I knew that they knew I would if I could but that I couldn't." In short, self-delusion was seen as having something of the same relation to alcoholism as fever does to other physical disorders. Fever must be reduced if the malady is to be treated and intervention is indicated; if the fever reaches certain heights it is lethal and intervention becomes imperative.

3. Finally, *alcoholism is treatable and treatment is available.* Hundreds upon hundreds of persons receive treatment in the State of Minnesota each year in public and private centers. Alcoholics Anonymous groups are only a few miles or minutes away from anyone who needs them. Those most helpful to the suffering alcoholics have been those whose concern and basic understanding en-

abled them to lead the alcoholic to such treatment. As one alcoholic put it, "If they had gone on thinking I could if I would, I'm sure I'd still be drinking . . . I might even be dead for all I know."

The forms of intervention and people considered to be most helpful were those where confrontations came *at depth*. Then, breaches in their defenses occurred. A wide range of approaches were described. The subjects recalled being identified specifically with physiological, mental, spiritual, and social involvements. Often it was a combination of some or all of them.

Medical doctors who actually described, in detail, liver, nervous, or other physical deteriorations, and *then tied them into diagnoses and treatment programs* were cited as helpful.

"Your liver has now become enlarged and any further use of alcohol places your life in jeopardy. At this point your liver can pretty much repair itself, but later on may be too late. If you cannot stop drinking by yourself, treatment is essential!" said one doctor.

"Nerve cells can be damaged irreparably by the overuse of alcohol. Some of what I see in your case seems to be a neurological involvement."

Another medical doctor, who was an alcoholic, described finally having to admit to himself the jaundiced condition of his own eyes! Alimentary disorders, tremors, and blackouts *when related to the illness by persons considered to be competent to do so were* useful to these people's recognition of their alcoholism.

Mental and spiritual involvements with the disease were also used to break through defenses. The one most often referred to by these recovered alcoholics was the *depression which preceded or accompanied their realization of their loss of control.* Disintegration of interpersonal relationships in families or other meaningful social settings when connected with uncontrolled use of the chemical became useful materials for confrontations. For the most part, however, the value of these despondent periods *tended to be misunderstood* by the "helpers." (A reason for this could be that such depressions for many alcoholics became quite severe. Most of the subjects, for example, admitted to suicidal thinking as the illness progressed. Many described suicidal attempts. The people around them became quite fearful as a result.) In any case, depressed times were not used as opportunities to break through denial barriers and self-delusions. The subjects reported that the "helpers" attempted instead simply to reduce and alleviate the depressions with chemicals or counseling! Again, delays in recognition were reported.

"If they had gone on thinking

All of these recovered alcoholics agreed that *they needed to realize they were caught in an unpredictable and uncontrolled pattern of behavior* before serious attempts at recovery were made. One subject put it succinctly "I had stopped drinking for periods of time before because I knew I shouldn't drink; then, at last, it dawned on me that I *had* to stop *because I couldn't quit!*"

Again, in the areas of the mental anguish and spiritual depressions of the illness, it was pointed out that these alcoholics were given no outside help with their rationalizations. "If only he (or she) had known more about the forces running my life, he could have been so much

more helpful," was a refrain in the study. Few reported any real help in being caused to face up to the truth that these sporadic attempts at withdrawal were not, *as they believed them to be,* "proofs of my ability to stop anytime I decided to do so." These withdrawals were, in fact, proofs of the opposite truth; namely, that every time *resumption of drinking had been inevitable* and at more severe, toxic, and harmful levels.

For the most part, their rationalizations that only those were alcoholics who "had to have a drink in the morning," or who could "only stay off it for a day or two at a time" went unchallenged. One woman related that she had evaded admission of her lack of control for years, "because I never drank before 5 p.m. Well, almost never, except at the end, and I stayed dry twenty-four consecutive days during that last year." Despite her other numerous and obvious mental, physical, and ethical symptoms, those around her apparently accepted these conditions as proof that her trouble was not alcoholism, but rather occasional immoderation!

Again, these recovered alcoholics reported having little or no real assistance from any "helpers" in achieving insight into the truth that their emotional, mental, and spiritual disorders *continued even in the withdrawn or "dry" periods.* Even when sober, they remained tense, nervous, easily frustrated, and anxious, because consciously and unconsciously, *they remained preoccupied with thoughts of drinking or not drinking.* As one spouse put it, "It doesn't matter whether you are sober or not, you just aren't the same person I married." An often expressed insight by these recovered subjects was, "No one ever explained to me alcoholism was a good deal more than alcohol." Others observed, "Now I see that when I went on the wagon those times, all I did was to go on a series of dry drunks."

Finally, nearly all these subjects agreed in retrospect that superficial, unrealistic, and inadequate appraisals of their conditions by themselves *and the meaningful persons around them* delayed their recognition that the disorder *was progressive in nature.* Crises in all the areas, physical, mental, and spiritual, were becoming more frequent and more severe as time passed, and yet they were not used as material for confrontations. For the most part, these alcoholics were allowed to deteriorate to the point where the illness itself became the confronter. Those few who had been confronted earlier joined in a fervent, "Thank God, they helped me to see how much worse it was becoming. With the way I was denying all of it to myself, I could have died, if they hadn't led me to see what the last two years had done to me."

One of the chief symptoms of the illness is a highly developed defense system of denial, rationalization, and projection. It is also one of the most obvious. People seeing it most often deal with it as lying. They see the truth being flaunted by one who is still responsible to that truth and *entirely able to know it.* They do not see that this defense system is now so highly developed that it has produced a real measure of self-delusion. The sicker the person, the more deeply entrenched self-evasion and self-deceit becomes.

At this point in the progression of

the disorder, it is no longer a question if he *will* recognize his condition but rather if he *can* recognize it. Nature itself has mercifully (and most unhelpfully) contributed to his blindness by providing more or less frequent blackouts of his most antisocial behavior. He literally cannot remember certain parts of his life. These parts provide him with no specific data, only a vague uneasiness, a nagging indefinable—at times almost crushing—anxiety. Adding to this growing uneasiness are the areas of his behavior which are only hazily recallable (now growing in number and severity) which he finds necessary to deal with by "trying his best to forget." Altogether, what his mind cannot remember adds up to so large an amount of material as to make it impossible for the sick person to deal with himself realistically any longer.

"Break Through" Crises Needed

His condition falls into a descending spiral of repetitive behavior and consequent feelings of shame, self-loathing, and bewilderment, resulting in further reinforcement of his defense mechanisms and an ever deepening delusion of self. Permanent physical disability or even premature death is inevitable unless this destructive process is interrupted successfully. Such interruption can come only in the form of a crisis which has been made significant enough to "break through" the defense system. Usually it requires a series of such crises to gain the necessary force cumulatively. Here is where the knowledgeable, meaningful person or persons must help by promptly calling attention to the reality and seriousness of the condition as each crisis occurs; avoiding either equivocation or recrimination.

Often this breakthrough is unnecessarily delayed by misguided or unknowing persons around the alcoholic who adopt either or both of the following tactics. The first is illustrated by the wife, who, when asked if she had confronted her husband with his condition, snapped back, "There isn't anything left in the house to throw at him!" These reactions may tend to ease her own frustrations, but what she calls confrontation is, in fact, viewed by him as punishment. Since he sees himself, consciously or unconsciously, as needing to be punished, the effect of such treatment is to alleviate his guilt feelings momentarily, thus enabling him to live less uncomfortably with his addiction. He continues to evade it in intensified self-pity or projected resentment. Similarly, the "sympathetic" approach made by many spouses may serve to make *them* "feel better" but the effect with the alcoholic is to reduce his anxiety level to the place where he lives with his uncontrolled drinking pattern less painfully, and, therefore, less realistically. Both approaches delay the arrival of the moment of truth which only objective confrontation achieves for him.

Perhaps the most helpful confrontation would be sound movies of the alcoholic's behavior. Lacking this, factual recounting of data which allow the suffering person to experience the full impact of the cost of his addiction to himself and those around him seems to be most effective.

"I found another empty bottle in the basement clothes hamper."

"This is the third time this month we had to break a supper engagement."

"Did you know that you bumped the table last night and broke the lamp?"

"Jim talked to me after the party

and told me how concerned he is becoming with your drinking pattern."

"Our neighbors mentioned this morning that they have noticed how withdrawn you have become in the last year and they wondered how they could help."

"Do you remember falling down in the bathroom at 2:00 a.m.?"

All those facts which he or she could not otherwise know or remember, presented objectively in those more clearheaded times when they can be assimilated, will then be added to what he or she does know and remember. *Facts,* (it should be underlined) not opinions or suppositions, are what ultimately helps break through the denial barrier. The process is painful. It can and usually does cause deeper depression. This is its purpose.

It is only at depth that the wall of self-delusion can be breached. All the while, love, concern, and, above all, hope should also be present in the confrontation of this dread disease. Those who report such early assistance join in a fervent "Thank God, they knew enough and cared enough to cause me to face it so early. It could have been so much worse."

In summary, contrary to what has been the popular opinion among many physicians, clergymen, spouses, and the general public itself, data gathered in the case studies of recovered alcoholics clearly indicated the usefulness of, even the necessity for, some form of intervention by those around the suffering alcoholic. There *is* a need to aid the insight and to direct the decision making of those whose own judgment has become impaired. Objective, unequivocal, and non-judgmental confrontation of the alcoholic with the reality of his condition was deemed most helpful.

CONTINUED FROM PAGE 23

with one another and remain sober through its fellowship.

Psychiatrists continue to play a major role in treatment programs. Many deep underlying problems must be treated in many persons before any group therapy can be effective and, of course, many individuals must depend on psychiatric care for any degree of recovery. The family physician can many times afford additional counselling, or guide the alcoholic into a program for continued recovery.

Various drugs are available to augment the treatment program. Anabuse has been of limited use. It blocks the digestion of alcohol and makes the patient unable to drink. Its side effects are sometimes worse than drinking. Flagyl has recently been similarly effective, with less severe toxic effects. Both these drugs are merely crutches and must be used in conjunction with other treatment. The tranquilizers must be used with caution and under strict medical supervision. Certainly underlying psychological problems can be treated with these drugs, but transfer from alcoholism to pillism is an increasing problem and far more dangerous. Addictions to sedatives and tranquilizers is a greater problem than alcoholism itself and should be avoided.

Recently the use of nicotinic acid and similar drugs have shown promise in helping the depression and some other aspects of this disease by preventing relapses while the patient is being treated. Again no pill cures alcoholism, only *self.*

The recovery of the foodoholic depends on a controlled diet, and recovery of the alcoholic depends on abstinence from alcohol.

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Almance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone 919-228-7053.

†*Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd.; Phone: 227-6271.

BUTNER—

‡*Aftercare Clinic; John Umstead Hospital;* Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Mental Health Clinic,* 102 Church St.; Phone: 786-1181.

DURHAM—

†*Department of Psychiatry, Duke University Medical Center;* Phone: 648-8111, Ext. 3416.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Mental Health Center;* Cape Fear Valley Hospital; Phone: 484-8123.

GASTONIA—

†*Gaston County Mental Health Clinic,* 206 N. Highland St.; Phone: 864-8381.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12.00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* Durwood Howard, Director; P. O. Box 1598; Phone: 919-735-7033.

†*Wayne County Mental Health Clinic,* 715 Ash St.; Phone: 735-4331.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: 273-8281.

†*Family Service Agency;* 1301 N. Elm St.

GREENVILLE—

†*Coastal Plain Mental Health Center,* 1827 West Sixth St.; Phone: 752-7151.

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

HENDERSON—

†*Vance County Mental Health Clinic,* County Home Rd.; Phone 492-1176 or 438-4813.

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 158 By-pass W; P. O. Box 1174; Phone: 919-438-3274 or 919-483-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

†*Henderson County Health Department;* Phone: 692-4223.

HIGH POINT—

†*Family Service of High Point,* 113 Gatewood Ave.; Phone: 883-1709 or 833-2119.

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

†*Scotland County Mental Health Clinic,* 1304 Biggs St.; Phone: 276-7360.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

**Burke County Council on Alcoholism;* Grady Buff, Educational Director; 211 N. Sterling St.; Phone: 704-433-1221.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

PINEHURST—

Sandhills Mental Health Center; Box 1098; Phone: 295-6851.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: 633-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

†*Anson County Health Department;* Phone: 694-2516.

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILMINGTON—

†*Southeastern Mental Health Center,* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

**Wilson County Council on Alcoholism;* W. H. Jennings, Director; Room 208, 116 S. Goldsboro St.; Phone: 919-237-0585.

WINDSOR—

**Bertie County Alcohol Information and Service Center;* Rev. Donald Dawson, Director.

WINSTON-SALEM—

***†Alcoholism Program of Forsyth County;* Robert Charlton, Educational Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

†*Department of Psychiatry, Bowman Gray School of Medicine;* Phone: 725-7261.

†*Forsyth County Mental Health Unit,* Seventh and Woodland; Phone: 722-0364.

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C. 27603

Second - Class
Postage Paid at Raleigh, N. C., 27602.